

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155247	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/24/2012
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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 8549 S MADISON AVE INDIANAPOLIS, IN 46227
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F0000	<p>This visit was for the Investigation of Complaints IN00117709 and IN00117826.</p> <p>Complaints: IN00117709 Substantiated. Federal/State deficiencies related to the allegation is cited at F323.</p> <p>IN00117826 Substantiated Federal/State deficiencies related to the allegations are cited at F282, F309 and F505.</p> <p>Survey dates: October 19, 22 & 24, 2012</p> <p>Facility Number: 000151 Provider Number: 155247 AIM Number: 100284060</p> <p>Survey Team: Mary Jane G. Fischer, RN</p> <p>Census Bed Type: SNF: 44 SNF/NF: 82 Total: 126</p> <p>Census Payor Type: Medicare: 20 Medicaid: 67 Other: 39</p>	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Total: 126</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on October 31, 2012 by Bev Faulkner, RN</p>			

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to ensure a resident's plan of care and physician orders were followed for 1 of 4 sampled residents. [Resident "B"].</p> <p>Findings include:</p> <p>1. a. The record for Resident "B" was reviewed on 10-19-12 at 11:50 a.m. Diagnoses included but were not limited to seizure disorder, mitral valve replacement, end stage renal disease, anemia and hypertension. These diagnoses remained current at the time of the record review. The record indicated the resident had outpatient hemodialysis treatments, three times a week at a local outpatient dialysis center.</p> <p>The resident was admitted to the facility on 08-01-12 after recent surgery, which included a mitral valve replacement. At the time of discharge to the facility the resident had physician orders which included Phenytoin [a medication used in the treatment of seizures and the generic for Dilantin] 100 mg [milligrams] - 3 - by</p>	F0282	<p>F 282</p> <p>It is the practice of Manor Care Indy South to provide or arrange services by qualified persons in accordance with each resident's written plan of care.</p> <p>What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice? Resident "B" no longer resides in facility.</p> <p>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? Like residents include those residents who have a history of seizure disorder and are treated with an anticonvulsant medication. A chart audit was completed, medication availability confirmed and care plans were updated as necessary.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur? Licensed nursing staffs have been in-serviced on the following: Ø Following the resident's plan of</p>	11/23/2012	

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	<p>mouth every evening at 5:00 p.m.</p> <p>Review of the resident's current plan of care, originally dated 08-30-12 indicated the resident was "at risk for Neurological deficiencies related to: Seizure diagnosis."</p> <p>Interventions to this plan of care included, "Administer meds [medications] per physician orders. If seizure activity occurs, place on side, maintain open airway. Remove obstacles to ensure safe environment, neurochecks per facility guidelines. Obtain labs as ordered and notify physician of results. Obtain vital signs as needed, report presence of seizure activity. Note duration, characteristic of tonic/clonic movement LPC [level of consciousness] etc. Report signs or symptoms of tremors, rigidity, dizziness, changes in level of consciousness, slurred speech."</p> <p>The record indicated while the resident received hemodialysis treatment on 08-07-12 at the local outpatient dialysis center, seizure activity was observed and the resident was transported to the emergency department of the local area hospital and subsequently admitted to the hospital.</p> <p>The resident was discharged from the</p>		<p>care</p> <ul style="list-style-type: none"> Ø Administering medications per physician order Ø Lab monitoring procedure <p>How the corrective action will be monitored to ensure the deficient practice does not reoccur?</p> <p>ADNS or designee will monitor medication administration of licensed nursing staff weekly to include nurses on days, evenings, nights and weekends for a total of 12 observations a week times four weeks and then monthly times 3 months to assure meds are administered as ordered and plan of care is being followed. At this time if results are below a 95% threshold the monitoring will become weekly until a 95% threshold is achieved.</p> <p>ADNS or designee will also monitor that care plan implementation is followed related to lab monitoring and physicians are notified of abnormal lab results per facility protocol daily times four weeks and then monthly times 3 months. At this time if results are below a 95% threshold the monitoring will become weekly until a 95% threshold is achieved.</p> <p>The results will be reviewed by QAA committee monthly.</p> <p>Date to be completed 11/23/2012</p>		

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	<p>hospital on 08-16-12 and had a physician order for Dilantin for 200 mg - two tablets [for a total of 400 mg daily] daily at 5:00 p.m.</p> <p>The September 2012 and October 2012 physician re-writes instructed the nursing staff to continue with the dosage of Dilantin as prescribed at the time the resident was discharged from the hospital on 08-16-12.</p> <p>Review of the medication reconciliation of returned medication, provided by the pharmacy and reviewed on 10-22-12 at 1:30 p.m., indicated the facility received 60 tablets, 200 mg each tablet, on 08-17-12 and a subsequent delivery of 60 tablets on 09-24-12.</p> <p>The Pharmacy documentation indicated 50 tablets were returned to them on 10-06-12.</p> <p>A reconciliation of the medications scheduled to be dispensed, with verification by Registered Nurse employee #4, the Assistant Director of Nurses, from 08-17-12 through 10-01-12 indicated only 28 tablets should have been returned to the pharmacy and not the 50 as indicated.</p> <p>b. The resident had a physician order,</p>			

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	<p>dated 08-30-12 which included Coumadin 4 mg daily.</p> <p>A subsequent current plan of care, originally dated 08-07-12, indicated "anticoagulant therapy to treat recent mitral valve replacement" at risk for adverse effects." Interventions to this plan of care included "Administer per physician orders, obtain labs as ordered and notify physician or results, report adverse effect such as blood in urine/stool, gums/nose, bleeding, bruising."</p> <p>The resident had physician orders, dated 08-30-12, for Coumadin [an anticoagulant] 4 mg, 1 tablet once daily at 5:00 p.m. for the recent replacement of the mitral valve with mechanical prosthesis on 07-19-12.</p> <p>In addition the resident had physician orders for PT/INR [Prottime/International Normalization Ratio] every week with instruction to notify the physician of the results.</p> <p>The PT/INR Coumadin (Warfarin) Flowsheet instructed the nursing staff the appropriate INR range for a resident with a Mechanical Heart Valve was 2.5 - 3.5. The result of the INR on 09-24-12 was 2.8 and the physician was notified and indicated there were no changes to the resident's anticoagulation medication at</p>			

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	<p>that time.</p> <p>The laboratory test for the INR on 10-01-12 indicated the result was 5.0. The Flowsheet indicated the physician was notified and the nursing staff received orders to "hold" the medication for "2 days."</p> <p>The laboratory document indicated the facility was notified of the abnormal test result on 10-01-12 at 11:41 a.m. A notation at the bottom of this document indicated "faxed [facsimile] to MCI [Manorcare Health Services] nurse not available by phone at 11:00 a.m."</p> <p>The bottom of this test result indicated handwritten "initials" as the document was "reviewed by," but lacked a date or time of the review and physician notification.</p> <p>Interview on 10-22-12 at 9:30 a.m., the Nurse Practitioner indicated she was not aware of the abnormal laboratory result until she "saw" the actual report. Further interview, the Nurse Practitioner was unable to indicate a specific time she reviewed the report but added she "leaves the facility by 5:00 p.m.," and "the nursing staff already had the order to hold the medication."</p>			

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	<p>The Physician order was dated 10-01-12 and indicated the nursing staff did not transcribe the order until 8:05 p.m.</p> <p>Interview on 10-22-12 at 12:15 p.m., Licensed Practical Nurse employee #8 verified she transcribed the physician order and verified her initials on the Medication Administration Record for October 2012, that she dispensed the medication to the resident at 5:00 p.m.</p> <p>This Federal tag relates to Complaint IN00117826.</p> <p>3.1-35(g)(2)</p>			

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F0309 SS=G	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to provide the necessary care and services for a resident, in that when a resident had seizure activity which required nursing intervention, physician and family notification, the nursing staff failed to protect the resident from potential injury from additional seizure activity which resulted in a subdural hematoma and eventual death, for 1 of 3 residents reviewed for seizures and or head injury in a sample of 4. [Resident "B"].</p> <p>Findings include:</p> <p>1.a. The record for Resident "B" was reviewed on 10-19-12 at 11:50 a.m. Diagnoses included but were not limited to seizure disorder, mitral valve replacement, end stage renal disease, anemia and hypertension. These diagnoses remained current at the time of the record review.</p> <p>The resident was admitted to the facility</p>	F0309	<p>F 309 It is the practice of Manor Care Indy South to provide all residents with the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being. What corrective actions will be taken for those residents who have been found to have been affected by the deficient practice? Resident "B" no longer resides in facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? Residents who have a history of seizure disorder with the potential for a significant change in condition that would require continued assessment and or emergent care have the potential to be affected by the same deficient practice. These residents will be provided with necessary care and services including at the time of admission implementation of low bed with</p>	11/23/2012	

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	<p>on 08-01-12 after recent surgery, which included a mitral valve replacement. At the time of discharge to the facility the resident had physician orders which included Phenytoin [a medication used in the treatment of seizures and generic for Dilantin] 100 mg [milligrams] - 3 - by mouth every evening at 5:00 p.m.</p> <p>Review of the resident's current plan of care, originally dated 08-30-12, indicated the resident was "at risk for Neurological deficiencies related to: Seizure diagnosis."</p> <p>Interventions to this plan of care included "Administer meds [medications] per physician orders. If seizure activity occurs, place on side, maintain open airway. Remove obstacles to ensure safe environment, Neurochecks per facility guidelines. Obtain labs as ordered and notify physician of results. Obtain vital signs as needed, report presence of seizure activity. Note duration, characteristic of tonic/clonic movement LOC [level of consciousness] etc. Report signs or symptoms of tremors, rigidity, dizziness, changes in level of consciousness, slurred speech."</p> <p>The record indicated while the resident received hemodialysis treatment on 08-07-12 at the local outpatient dialysis</p>		<p>mat, safely arrangement of furniture and will have an immediate evaluation by a Licensed nurse should change of condition occur. The physician, family and nursing unit manager will also be notified and any new orders will be implemented.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>Licensed nursing staffs have been in-serviced on the following:</p> <ul style="list-style-type: none"> Ø How we will protect the resident of potential injury from seizure activity through initial and ongoing evaluation, initiation of low bed and mats at the time of admission, monitoring furniture arrangement Ø Assessment, care and evaluation of a patient's significant change in condition post seizure activity Ø Administering medications per physician order Ø Lab monitoring procedure Ø Any circumstance could lead to a patient being sent to hospital based on the decision of the physician, family, or clinical judgment of the nurse if unable to talk to attending physician, family or medical director. <p>How the corrective action will</p>		

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	<p>center, seizure activity was observed and the resident was transported to the emergency department of the local area hospital and subsequently admitted to the hospital.</p> <p>The resident was discharged from the hospital on 08-16-12 and had a physician order for Dilantin for 200 mg - two tablets [for a total of 400 mg daily] daily at 5:00 p.m.</p> <p>The September 2012 and October 2012 physician re-writes instructed the nursing staff to continue with the dosage of Dilantin as prescribed at the time the resident was discharged from the hospital on 08-16-12.</p> <p>Review of the medication reconciliation of returned medication, provided by the pharmacy and reviewed on 10-22-12 at 1:30 p.m., indicated the facility received 60 tablets, 200 mg each tablet, on 08-17-12 and a subsequent delivery of 60 tablets on 09-24-12.</p> <p>The Pharmacy documentation indicated 50 tablets were returned to them on 10-06-12.</p> <p>A reconciliation of the medications scheduled to be dispensed, with verification by Registered Nurse</p>		<p>be monitored to ensure the deficient practice does not reoccur?</p> <p>ADNS or designee will monitor daily for change of condition of residents with history of seizure disorder to assure licensed nurse evaluates immediately, notify physician, family and nursing management. This will be completed weekly times four weeks and then monthly times 3 months.</p> <p>ADNS or designee will review MD orders daily for new and ongoing anticonvulsant lab orders and monitoring. This will be completed weekly times four weeks and then monthly times 3 months.</p> <p>ADNS or designee will audit the chart of newly admitted residents, and complete a visual validation on residents with a history of seizure disorder to assure there is an intervention on care plan to implement low bed and mats as well as appropriate furniture arrangement to protect from potential injury.</p> <p>ADNS or designee will monitor medication administration of 6 licensed nursing staff per week to assure meds are administered as ordered and plan of care is being followed. This will be completed weekly times four weeks and then monthly times 3 months. At this time if results are below a 95% threshold the monitoring will become weekly until a 95% threshold is achieved</p> <p>Date to be completed</p>				

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	<p>employee #4, the Assistant Director of Nurses, from 08-17-12 through 10-01-12 indicated only 28 tablets should have been returned to the pharmacy and not the 50 as indicated.</p> <p>b. In addition, the resident had a physician order, dated 08-30-12, which included Coumadin 4 mg daily.</p> <p>A subsequent current plan of care, originally dated 08-07-12, indicated "anticoagulant therapy to treat recent mitral valve replacement" at risk for adverse effects."</p> <p>Interventions to this plan of care included "Administer per physician orders, obtain labs as ordered and notify physician or results, report adverse effect such as blood in urine/stool, gums/nose, bleeding, bruising."</p> <p>Interview on 10-22-12 at 12:00 p.m., Licensed Practical Nurse employee #8 indicated that on 10-01-12, "[name of resident] had the call light on around 8:00 p.m. or 8:30 p.m. and when I went in there [resident name] was postictal [observation of resident after the seizure occurred] laying on the right side like [resident] had been sitting in bed. There was brown drainage out of [resident]</p>		11/23/2012	

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	<p>mouth. The other nurses helped me and we positioned [resident name] to the middle of the bed on back. I had to start oxygen because the oxygen saturation level I think was in the 70's. I called the doctor and was told to just monitor and when [resident] started to come out of it [the seizure activity] [resident] was incontinent. I called [resident's family member] and told what had happened and at that time [resident] was making a snoring noise after the seizure. [Family member] asked if we were going to send [resident] to the hospital and I said that if it happened again we probably would send [resident] out for an evaluation. When I finally left the room [resident] when talking to [family member] on the telephone. I went back a little later and [resident] seemed alert, the vital signs were normal and I took off the oxygen. [Resident] told me [resident] was fine but just tired. When I left [resident] was in bed in a normal position. [Resident] was not a fall risk and there was no mat and the bed was not in a low position. We don't use siderails here so there is nothing to pad. I know [resident] had a seizure a few months earlier at the dialysis clinic but nothing recently. Around 11:00 p.m., the CNA yelled for the nurses and we found [resident name] on the floor laying on the right side of the bed but on [resident] left side. The nightstand was</p>			

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	<p>on the right side of the bed and [resident] head was up against the front of the nightstand and there was bleeding from [resident] mouth. After the first seizure we didn't move any furniture back or out of the way. [Resident] seemed alert just drowsy. The other nurse called 911 and we sent [resident] out."</p> <p>Review of the Progress Notes, dated 10-01-12 at 23:15 [9:15 p.m.] indicated the following: "Pt. [patient] found beside bed, face down with head near the night stand approx. [approximately] 1 foot. Pt. not reonsive [sic]. Post ictal [sic] breathing. Call placed to 911 to request transport pt to ER [Emergency Room]. M.D. [Medical Doctor] office notified and order was obtained for pt. to go to [name of local area hospital] for eval. [evaluation]. At 2308 [9:08 p.m.] O2 [oxygen] SAT [saturation] was 52 and HR [heart rate] = 123. O2 was applied and O2 SAT 70 %, and HR = 127. At 2311 [9:11 p.m.] O2 SAT = 80 % and HR = 101. At 2313 [9:13 p.m.] O2 SAT 88 % and HR = 117, and B/P [blood pressure] = 188/144. Pt's [family member] was notified of pt. going to [name of local area hospital] ER."</p> <p>Review of the hospital record on 10-19-12 at 8:30 a.m., indicated the resident was transported to the local</p>			

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	<p>hospital emergency room and was diagnosed with a seizure, a subtherapeutic Dilantin level, an elevated PT/INR [Protime International Normalization Ratio] level and a subdural bleed.</p> <p>The emergency room notes also indicated that prior to taking a chest x-ray the "pt. [patient] in active grand mal seizure just prior to taking portable chest x-ray."</p> <p>In addition, the emergency room notations indicated the resident "had 2 seizures today, has no recollection of the events, apparently woke up on the floor or was found on the floor face down. [Resident] has a contusion to the forehead to the right of midline, and another contusion to the left brow, and was given 1000 PE equivalents of Dilantin for a subtherapeutic Dilantin." The hospital record indicated the resident's Dilantin level was "5.6 "L" [low], with a reference range of 10 - 20." The last Dilantin level drawn at the facility also indicated the resident's Dilantin level was low at "3" with a reference range of 10 - 20.</p> <p>While in the Emergency Room, due to the resident's low Dilantin level received "1000 mg [milligrams] of Dilantin in the emergency room" and in addition the resident's PT/INR [Protime/International Normalization Ratio] was 5.1/50.9 [sic]</p>			

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	<p>[with reference ranges to include [2.5 - 3.5/8.9 - 11.9]. The record indicated the received "Vitamin K 2.5 mg by a cardiologist" while the resident was in the Emergency room.</p> <p>At the time of admission to the Emergency Room a head CT [cat scan] was performed and indicated the resident had a "small subdural in the left temporal lobe that is approximately 0.7 cm [centimeters] by 3.5 cm."</p> <p>The hospital notation indicated the resident was transferred to the Intensive Care Unit from the Emergency Room but "seems to be getting more somnolent. [Resident] is not waking up or following commands in any meaningful way with intermittent airway obstruction - with loud snores and grunts."</p> <p>An addendum to the Hospital History and Physical, dated 10-02-12 indicated "the [Resident] had a generalized tonic-clonic seizure at ECF [extended care facility] around 9:00 p.m. 10-01-12 and subsequently had several "smaller" seizures after that. Around 11:00 p.m. was found on the floor face down by the ECF staff and was transferred to [name of local area hospital] for further evaluation. [Resident] is chronically on Warfarin for atrial fib. [fibrillation] and mechanical</p>			

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	<p>mitral valve." A subsequent CT scan was completed [10-02-12] "in the morning, after the patient became more and more somnolent, showed significant enlargement of the subdural hematoma, now with about a 2 cm [centimeter] midline shift."</p> <p>"Impression: significant increase in the size of the acute left frontoparietal subdural hemorrhage now measure approximately 2 cm in thickness in the left frontal region. Significant mass effect 18 mm of left to right midline shift at the level lateral ventricle is noted. Mass effect with deformity and distortion of the mesencephalon is observed. Mild partial entrapment of the right lateral ventricle is present."</p> <p>The Hospital Discharge Summary indicated "Cause of Death: Left frontal contusion with left subdural hematoma after a fall with Contributing Causes Include 1. A seizure due to above."</p> <p>Interview on 10-22-12 at 9:20 a.m., the Director of Nurses provided documentation of Inservice Education, as indicated above, in regard to seizures, dated 10-03-12. The Director of Nurses indicated the Inservice Education was conducted due to the seizure activity and subsequent transportation to the hospital</p>			

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	<p>in regard to [name of Resident "B"].</p> <p>Review of a facility policy on 10-22-12 at 9:20 a.m., and dated 01-2011 indicated the following:</p> <p>"SEIZURE PRECAUTIONS: GUIDELINES FOR CARE - PURPOSE [bold type and underscored]: To protect patient from injury during a seizure and to evaluate and document observations prior to, during and after a seizure."</p> <p>"PROCEDURE [bold type and underscored] - Care During a Seizure [bold type and underscored]:</p> <ol style="list-style-type: none"> Note the signs of impending seizure - change in behavior or unusual sensations (aura). Maintain airway and safety of patient - Position the patient on side if on a flat surface (bed or floor). Do not put anything in the patient's mouth. If sitting, turn patient's head to side. Loosen patient's clothing around neck. Do not restrain; protect the patient from injury. Record time of onset, duration and termination of seizure - Extremity or extremities where seizure started (bilateral or unilateral). Was there an aura (yelling, bizarre smell). Head and eye movement and changes in pupils. 			

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	<p>Type of muscle response (tonic/clonic - marked by alternate contraction and relaxation of muscle). Respiratory status or change. Urinary/bowel incontinence. Loss of consciousness. Ability to control movements. Any injuries that occurred.</p> <p>Post Seizure Care [bold type and underscored] -</p> <p>8. Position the patient on their side unless contraindicated.</p> <p>9. Observe the patient for post seizure symptoms, headaches or confusion.</p> <p>10. Check the patient's neurological status - level of consciousness, pupil reactions, vital signs, movement and extremity strength (left or right weakness, etc), increased oral secretions - patient may need suctioning.</p> <p>11. Notify physician of seizure: have available - Events leading to, during and after seizure. List of anticonvulsant's, any missed anticonvulsant's or refusals, also any pertinent laboratory results especially most recent anticonvulsant level."</p> <p>The record lacked the resident's neurochecks, ensure the resident remained on side and documentation the physician was notified of the subtherapeutic</p>			

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	<p>Dilantin level as outlined in the policy.</p> <p>Review of the facility policy on 10-24-12 at 8:30 a.m., the "NEUROLOGICAL: NEUROLOGICAL EVALUATION," policy dated 3/2010 indicated the following:</p> <p>"PURPOSE [bold type and underscored] a neurological evaluation is used to establish a baseline neurological status upon which subsequent evaluations may be compared and changes in neurological status may be determined."</p> <p>"PROCEDURE [bold type and underscored] 4. After the completion of initial neurological evaluation with vital signs, continued evaluations every 30 minutes times 4, then every 1 hour times 4, then every 8 hours times 9 for the next 72 hours."</p> <p>When interviewed on 10-22-12 at 12:50 a.m. the Director of Nurses indicated the Neurochecks were not completed as directed per policy by the nursing staff.</p> <p>This Federal tag relates to Complaint IN00117826.</p> <p>3.1-37(a)</p>			

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F0323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure supervision and/or assistive devices to alert the nursing staff of unassisted ambulation, movement or safe transfer which resulted in a head injury [hematoma] which required transport to the local area hospital for evaluation, skin tear which required treatment and bruising [Resident "A"] for 3 of 3 resident's reviewed for falls in a sample of 4. [Residents "A", "C" and "D"].</p> <p>Findings include:</p> <p>1.a. The record for Resident "A" was reviewed on 10-19-12 at 11:45 a.m. Diagnoses included but were not limited to brain cancer, seizure disorder, muscle weakness and hypertension.</p> <p>Review of the resident's Minimum Data Set assessment, dated 07-17-12, indicated the resident's balance was not steady and only able to stabilize with staff assistance when moving from a seated to a standing position, moving on/off the toilet and</p>	F0323	<p>F 323 It is the practice of Manor Care Indy South to provide a resident environment that remains as free of accident as is possible. What corrective action will take place for those residents found to be affected by the deficient practice? The charts for Resident "A", "C", and "D" were reviewed; functional status and level of assist updated; care plan focus include current fall risk, MD ordered interventions and assistive devices are in place. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? Residents determined to be a fall-risk and residents who have fallen, will be evaluated by a licensed nurse to determine root cause of fall, current fall functional risk factors, level of assist and cognition; interdisciplinary team will review these risks and or falls and each resident's fall care plan will be reviewed to assure interventions are in place to address the resident's current</p>	11/23/2012

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	<p>surface to surface transfers.</p> <p>Review of the resident's current Plan of care, originally dated 12-20-11, indicated the resident was "at risk for falls due to unsteady gait, cognitive impairment, poor safety awareness, a history of falls, history of left hip fracture narcolepsy and cerebral edema."</p> <p>Interventions to this plan of care included "Assess for fall risk upon admission and reassess as needed."</p> <p>The record indicated the facility updated the resident's plan of care on 06-25-12 with a "scoop mattress," and on 07-09-12 with "low bed with mats."</p> <p>However the record indicated on 08-20-12 at 9:00 a.m., the resident "was sitting in wheelchair out in hallway when [resident] leaned over trying to reach [resident] shoe, when inadvertently slipped out of wheelchair landing on the left side of body. See nurses notes."</p> <p>The nursing progress notes, dated 08-20-12 at 9:00 a.m., in regard to the resident's fall indicated "Extrinsic factors: [resident] posture by leaning forward."</p> <p>Review of the plan of care lacked a "focus problem" to identify the resident's posture, leaning forward or any</p>		<p>level of assistance, cognition and functional risk factors</p> <p>a new intervention will be initiated immediately post fall care plan will be updated to include any new interventions New admissions will have a fall assessment and interventions implemented as necessary upon admission based on cognition, functional status and level of assistance required. The Director of Care Delivery/designee updates the resident kardex used by direct care staff with new/changes in fall interventions and completes a bedside validation.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>Licensed nursing staff have been re-inserviced on post fall evaluation and implementation of fall interventions. The Director of Care Delivery/designee updates the resident care plan and kardex used by direct care staff with new/changes in fall interventions and completes a bedside validation.</p> <p>Additional education to include licensed nursing staff to immediately notify nursing manager verbally when manager is in building and when not in building the staff will immediately call the nursing manager when a resident has a fall to insure new fall interventions are appropriate,</p>				

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	<p>"intervention."</p> <p>Review of the incident report, dated 09-13-12 at 11:00 a.m., the writer "heard loud thud coming from res. [resident] room. Resident found on floor on left side. Head facing doorway. ST [skin tear] to left elbow - cleaned with NS [normal saline] xeroform applied, wrap [sic] in Kerlix. Bruising to left side of head/face and bilateral knees."</p> <p>The section of the incident report titled "documentation" indicated "Writer heard loud thud coming from res. [resident] room. When entering the res. was on the left side on floor head facing the door. W/C [wheelchair] to the right side of res. with unlocked W/C brakes unlocked [sic]. ST to left elbow and bruising to left side of face/bilateral knees already appearing [sic]. Resident c/o [complains of] dizziness and stiffness."</p> <p>Review of the plan of care lacked a "focus problem" to ensure the resident's brakes were locked when leaving the resident unattended, and failed to develop or document an intervention.</p> <p>The 10-03-12 progress notes at 7:35 a.m., indicated the resident was "sitting in W/C at nurses station eating breakfast when fell forwards onto floor, hitting forehead</p>		<p>timely with update to the plan of care and kardex. If after 15 minutes, nursing staff are unable to have verbal phone dialogue with unit manager, the ADNS will be notified.</p> <p>How will the corrective actions be monitored to ensure they do not occur again? A QAA monitoring tool will be completed by ADNS/Designee on post fall evaluation, intervention implementation and physician notification of need for new fall intervention. This will be completed weekly times four weeks and then monthly times 3 months. At this time if results are below a 95% threshold the audits will become weekly until a 95% threshold is achieved. The results will be reviewed by QAA committee monthly.</p> <p>By what date will the changes occur? 11/23/2012</p>				

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	<p>on floor. P [pulse] 49, R [respirations] 18, B/P [blood pressure] 174/110. Muscle strength and mobility poor but that is WNL [within normal limits] for res. Res. does have small hematoma on right aspect of forehead from where head hit floor. MD [Medical Doctor] notified and rec'd [received] order to send to ER [Emergency room] due to abnormal VS if family agrees."</p> <p>Review of the Incident report also dated 10-03-12 at 8:03 a.m., indicated the resident had a "fall and hit head on floor. Resident has a history falls [sic]and CA [cancer] wiuth [sic] mets [metastasis] to the brain."</p> <p>The nurses progress notes, dated 10-03-12 at 8:35 a.m., indicated the resident "is noted to be more lethargic at this time. Awaiting transport to ER [emergency room]."</p> <p>The resident was sent to a local area hospital and diagnoses with "cerebral edema, fall from bed, and cephalohematoma."</p> <p>The progress notes indicated that at the time the resident returned to the facility the resident had a "hematoma remains on "R" [right] aspect of forehead."</p>			

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	<p>The resident's plan of care indicated a Broda chair was placed as an intervention on 10-04-12, after the resident fell from the wheelchair and sustained injuries during two of the three falls.</p> <p>Review of the Physician Progress notes, dated 08-20-12, indicated "res. was leaning forward in w/c and fell out causing redness to right knee and forearm. Cont. [continue] fall precautions." The Physician Progress Note, dated 08-22-12, indicated the resident also "fell from the W/C today - no apparent injury - weakness, stiffness, and increased confusion." The Physician Progress Note, originally dated 10-03-12, but "lined through" and then documented as 10-04-12 indicated the resident "fell from bed and hit head, sent to ER for eval. [evaluation]. Pt. [patient] overall prognosis poor, pt increased risk for falls secondary to CNS [central nervous system] lymphoma."</p> <p>Interview on 10-23-12 at 9:48 a.m., an interested family member indicated that a staff member said that when [name of resident] fell from the wheelchair while in room [09-13-12], it sounded like a watermelon hit the floor. Sometimes [name of resident] sees things on the floor and will reach out for it. The nursing staff should know that by now and should</p>			

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	<p>have done something to keep [resident] from falling face first out of the wheelchair."</p> <p>The resident had four falls from the wheelchair without the facility staff providing additional interventions to protect the resident from injury.</p> <p>2. The record for Resident "C" was reviewed on 10-19-12 at 1:25 p.m. Diagnoses included but were not limited to Seizure activity, history of falls, and Alzheimer's dementia. These diagnoses remained current at the time of the record review.</p> <p>The resident was admitted to the facility on 10-17-12.</p> <p>Review of the Hospital Progress Notes, dated 09-20-12 and received via fax [facsimile] on 10-16-12, indicated the resident had "Falls - Family report multiple falls at home and Alzheimer's dementia with family "reported difficulty managing care. Suspect stair step progression of dementia."</p> <p>The record indicated the resident was admitted to the facility on 10-17-12 at 12:15 p.m., and on 10-18-12 at 6:30 a.m., the resident was found on the floor in the bathroom by the CNA [certified nurses aide]. "Resident stated was going to</p>			

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	<p>bathroom et [and] attempting to return to w/c. Res. [resident] stated right elbow hurt et was reddened upon inspection. Res. was supporting weight on that arm while on floor. Once up in w/c et able to move extremity res. stated discomfort had decreased."</p> <p>The resident record contained two "Fall" assessments, both dated 10-18-12 at 18:15 [6:15 p.m.], over 24 hours after the admission and 12 hours after the resident was found on the floor of the bathroom.</p> <p>Both assessments contained the same information related to physical performance limitations, medications, disease and conditions, laboratory test, and environmental factors.</p> <p>The section titled "documentation" on both assessments and indicated "diagnosis of seizure disorder, Alzheimer's, HTN [hypertension], depression, and DM [diabetes mellitus]. Accucheck at time of incident was 67. Res. given dinner along with cookie and juice. Instructed res. to push call light when needing assistance. Call light within reach. Res. to be toileted every 2 hours."</p> <p>During interview on 10-22-12 at 2:00 p.m., the Director of Nurse indicated one of the "Fall" assessments was the initial assessment and the other was the</p>			

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	<p>assessment after the fall on 10-18-12.</p> <p>Interview on 10-24-12 at 8:30 a.m., the Director of Nurses provided a subsequent "Fall" admission assessment, dated 10-17-12 at 15:20 p.m. [3:20 p.m.]. This assessment indicated the resident used a wheelchair, had bowel and bladder incontinence a history of falls, had moderately impaired decision making skills with poor decision making skills with cues and supervision required. The resident's ability for "functional status" was not completed, and lacked any additional "documentation" by the nursing staff to include observations or comments "not captured in the previous questions. When further interviewed the Director of Nurses indicated the nursing staff provided a low bed and mats to the floor, but failed to included additional interventions including a toileting program for a cognitively impaired resident to assist with toileting needs.</p> <p>Although the resident was admitted to the facility with a history of falls with noted concerns by the family members, the record lacked MD notification/intervention on behalf of the resident and the facility's failure to do a thorough assessment and planned interventions.</p>			

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	<p>3. The record for Resident "D" was reviewed on 10-22-12 at 11:00 a.m. Diagnoses included but were not limited to mental retardation, encephalopathy, accidental fall and intermittent explosive disorder. These diagnoses remained current at the time of the record review. The resident was admitted to the facility on 09-26-12.</p> <p>The resident's current plan of care, originally dated 09-27-12, indicated the resident "at risk for falls due to arthritis, impaired mobility, DX. [diagnosis] of MR [mental retardation] and involuntary movements."</p> <p>Interventions to this plan of care with the original initiation date of the intervention included "2 person transfer with showers 09-28-12."</p> <p>The admission "Fall" assessment indicated the resident did not have physical performance limitations, did not have impulsivity or poor safety awareness, cognitive impairment or chronic or acute condition resulting in instability, laboratory testing.</p> <p>However; further review of the record indicated the resident required extensive assistance and two staff members with transfer, bed mobility and bathing. The resident was only able to maintain balance</p>			

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	<p>with staff assistance when moving from seated to standing position, on/off toilet and surface to surface transfer.</p> <p>A Falls assessment, dated 09-28-12 at 15:38 [3:38 p.m.] indicated the "intervention begun of 2 per person assist at all times."</p> <p>Review of the Progress notes, dated 09-29-12 at 00:05 [12:05 a.m.] "Resident was in shower room and was being transferred to chair when the CNA could no longer hold [resident] up and was lowered to the floor. Intervention put in place to use assist times 2 when transferring res. [resident] Will monitor."</p> <p>The incident report indicated the following "date of incident 09-26-12 [sic] at 9:45 a.m. [sic] "resident was attempting to self transfer self in shower room and was lower [sic] to this floor by staff."</p> <p>Interview on 10-24-12 at 8:30 a.m., the Director of Nurses provided a subsequent "Fall" admission assessment, dated 09-26-12 at 8:30 p.m.</p> <p>This assessment indicated the resident used a wheelchair, lacked documentation the resident had a catheter, had severely impaired decision making skills, but lacked the resident had a history of falls. The resident's ability for "functional</p>			

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	<p>status' was not completed, and lacked any additional "documentation" by the nursing staff to include observations or comments "not captured" in the previous questions. When further interviewed the Director of Nurses indicated the nursing staff provided a low bed and mats to the floor, but failed to included safe transfer interventions used for this resident.</p> <p>Although the resident was admitted to the facility with a history of accidental falls, the record lacked MD notification/intervention on behalf of the resident and the facility's failure to do a thorough assessment and planned interventions.</p> <p>4. Review of the facility "Falls Practice Guide Flowchart," on 10-22-12 at 9:20 a.m., prompted the nursing staff to "assess" the resident. If the resident had a history of falls or at risk for falls to "contact physician for orders," develop an "initial plan of care, and the "initial/update patient information worksheet, Kardex, task list," The "Practice Guidelines also prompted the nursing staff to develop a "plan" and revise the initial or interdisciplinary care plan as applicable." After the "implementation" of the plan the nursing staff was instructed to "evaluate" the interventions for effectiveness.</p>			

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	<p>This Federal tag relates to Complaint IN00117709.</p> <p>3.1-45(a)(2)</p>			

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F0505 SS=D	<p>483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. Based on record review and interview, the facility failed to promptly inform the physician when a resident had an elevated blood level requiring intervention for 1 of 1 resident reviewed receiving anti-coagulation therapy in a sample of 4. [Resident "B"].</p> <p>Findings include:</p> <p>The record for Resident "B" was reviewed on 10-19-12 at 11:50 a.m. Diagnoses included but were not limited to mitral valve replacement, seizure disorder, end stage renal disease, anemia and hypertension. These diagnoses remained current at the time of the record review.</p> <p>The resident had a physician order, dated 08-30-12 for Coumadin [an anticoagulant] 4 mg, 1 tablet once daily at 5:00 p.m. for the recent replacement of the mitral valve with mechanical prosthesis on 07-19-12. In addition the resident had physician orders for PT/INR [Prottime/International Normalization Ratio] every week with instruction to notify the physician of the results.</p>	F0505	<p>F505 It is the practice of Manor Care Indy South to promptly notify physician of lab results. What corrective action will be accomplished for those residents who have been affected by the deficient practice? Resident "B" no longer resides in facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? Residents with orders for anticoagulants have the potential to be affected by the same deficient practice. These residents with ordered anticoagulants were reviewed and changes implemented as needed. Lab tracking process is in place. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not reoccur? Licensed nursing staffs have been in-serviced on: Ø Anticoagulant lab monitoring and tracking procedure, including physician notification and documentation process How will corrective actions be</p>	11/23/2012	

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	<p>The PT/INR Coumadin (Warfarin) Flowsheet instructed the nursing staff the appropriate INR range for a resident with a Mechanical Heart Valve was 2.5 - 3.5. The result of the INR on 09-24-12 was 2.8 and the physician was notified and indicated there were no changes to the resident's anticoagulation medication at that time.</p> <p>The laboratory test for the INR on 10-01-12 indicated the result was 5.0. The Flowsheet indicated the physician was notified and the nursing staff received orders to "hold" the medication for "2 days."</p> <p>The laboratory document indicated the facility was notified of the abnormal test result on 10-01-12 at 11:41 a.m. A notation at the bottom of this document indicated "faxed [facsimile] to MCI [Manorcare Health Services] nurse not available by phone at 11:00 a.m."</p> <p>The bottom of this test result indicated handwritten "initials" as the document was "reviewed by," but lacked a date or time of the review and physician notification.</p> <p>Interview on 10-22-12 at 9:30 a.m., the Nurse Practitioner indicated she was not aware of the abnormal laboratory result</p>		<p>monitored to ensure that they do not reoccur? ADNS or designee will monitor for anticoagulant labs daily on residents with MD orders for anticoagulants to assure proper notification and documentation. This will be completed weekly times four weeks and then monthly times 3 months. At this time if results are below a 95% threshold the audits will become weekly until a 95% threshold is achieved. The results will be reviewed by QAA committee monthly.</p> <p>By what date will the changes occur? 11/23/2012</p>		

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	<p>until she "saw" the actual report. Further interview the Nurse Practitioner was unable to indicate a specific time she reviewed the report but added she "leaves the facility by 5:00 p.m.," and "the nursing staff already had the order to hold the medication."</p> <p>The Physician order was dated 10-01-12 and indicated the nursing staff did not transcribe the order until 8:05 p.m.</p> <p>Interview on 10-22-12 at 12:15 p.m., Licensed Practical Nurse employee #8 verified her initials on the Medication Administration Record for October 2012, that the resident received the medication at 5:00 p.m. on 10-01-12.</p> <p>This Federal tag relates to Complaint IN00117826.</p> <p>3.1-49(f)(2)</p>			